

Maternal-Infant Health Program Design Workgroup Notes

May 19, 2005

Present: Bonnie Ayers, Dianna Baker, Sandra Brandt, Suzette Burkitt-Wesolek, Alethia Carr, Janine Chittenden, Ingrid Davis, Paulette Dobynes Dunbar, Stacey Duncan-Jackson, Sheila Embry, Brenda Fink, Judy Fitzgerald, Pat Fralick, Eileen Guilford (for Diane Revitte), Sue Gough, Mary Ludtke, Deb Marciniak, Sue Moran, Jackie Prokop, Paul Shaheen (with guest from Toronto), Linda Suh (U of M nurse-midwifery student), Tom Summerfelt, Betty Tableman, Peggy Vander Meulen, Darlene VanOveren (for Rick Haverkate), Jackie Wood, Betty Yancey.

Present via phone: Anne Bianchi, Sr. Barbara Cline, Nancy Heyns, Anne Young.

Not present: Mark Bertler, Lynette Biery, Dianne Douglas, Sheri Falvay, Adnan Hammad, Rick Haverkate, Ed Kemp, Phyllis Meadows, Rick Murdock, Doug Paterson, Mary Pat Randall, Carolynn Rowland, Diane Revitte, Sharon Wallace.

Future MIHP Design Workgroup Meeting Dates

Thurs., June 16, 2005	1:00 – 3: 30 pm	MPHI Interactive Learning Center
Thurs., July 14, 2005	1:00 – 3:30 pm	MPHI Interactive Learning Center
Thurs., Aug 18, 2005	1:00 – 3:30 pm	MPHI Interactive Learning Center
Thurs., Sept. 8, 2005	1:00 – 3:30 pm	MPHI Interactive Learning Center
Tues., Oct. 4, 2005	1:00 – 3:30 pm	MPHI Interactive Learning Center
Tues., Nov. 8, 2005	1:00 – 3:00 pm	MPHI Interactive Learning Center
Tues., Dec. 6, 2005	1:00 – 3:30 pm	MPHI Interactive Learning Center

Tasks / Assignments

1. Brenda and Ingrid will inform Doug Paterson that the DWG has recommended that DHS be encouraged to include MIHP participation as a way for a mother to meet her Work First requirement during her infant's first 12 months.
2. Ingrid will ask MSS/ISS providers to share their data templates with the MIHP Data Tracking Workgroup.
3. Within the next few weeks, the MIHP Steering Committee will make a determination as to how the maternal screener will be implemented as of Oct. 1, 2005 (i.e., Part A and/or Part B).

Introduction of New Members

Brenda welcomed our three new Early On MIHP Design Workgroup (DWG) representatives: Jean Chittenden, Ottawa County Health Department; Sr. Barbara Cline, Early On Training & TA; and Jackie Wood, MDE Early Childhood and Parenting Programs. Early On also has initiated a major re-design process. Brenda said that we needed representatives on each other's re-design committees so that decisions made by one group fit with the decisions made by the other. For example, we'll be in trouble if we both assume we'll make referrals to each other, thinking that it's the other party's responsibility to provide service coordination, but the capacity just isn't there.

Key Questions Raised by MSS/ISS Providers at “Introducing the MIHP” April 2005 Trainings

Brenda reported on the April MSS/ISS trainings that were held in Southgate, Grand Rapids, Saginaw, and Traverse City (videoconference with sites in Copper County, Marquette and Sault Ste. Marie) to introduce the MIHP. Brenda, Lynette, and Tom presented the FY 01 MSS/ISS data analysis, the goals and overall design of the MIHP, the maternal screener, and the intervention matrix – all pieces that the DWG has previously reviewed. By and large, the trainings went well. Participants felt they better understood the reasons behind the redesign and the need to collect outcome data. At the end of each session, we asked: 1) Do you better understand the process? (Most raised their hands); 2) Does the new model make sense to you and can you generally support it? (Some raised their hands); or 3) Does the new model sound like the worst idea that the state has ever had? (Some brave souls raised their hands).

Deb captured the questions and answers from all four sessions. They will be posted on the MIHP web site ASAP. The discussions were very useful for the state people – we learned as much as anyone else did from them.

There were many questions about the maternal screener. Southeast Michigan was concerned that there were only a few nutrition questions in the screener based on the assumption that WIC has the primary responsibility for addressing nutrition for low-income mothers and infants. In Southeast Michigan, the interface between WIC and MSS/ISS is not as strong as it is in other parts of the state - providers said if the MIHP doesn't address nutrition, pregnant Medicaid beneficiaries would go without nutrition services. This reflected an overall concern that as we move forward and narrow the number of domains that the MIHP will address, other domains may be ignored because services to address them don't exist in the community.

There also were many questions about:

- How the data was collected for the FY 01 MSS/ISS analysis, in that providers had not been asked to submit outcome data.
- The family planning waiver, which is part of DCH's broader initiative to reduce infant mortality.
- Case rates.
- What changes to expect as of Oct. 1, 2005.
- Women who decline MSS/ISS services – WIC offers them something they really want, but we don't.

Women Who Decline MSS/ISS Services

Paul noted that Betty Tableman submitted a paper to Marianne Udow, DHS Director, asking her to revisit the social contract we have with women who receive public assistance to allow them to participate in the MIHP as a way to meet Work First requirements. He suggested that we initiate a workgroup across departments to work on

this because it's a technical issue with systems implications. We would need to objectively report the MIHP outcomes for these women to DHS – it wouldn't just be a way for women to escape the work requirement. We need to make the case that it's in the state's best interest to allow this. Betty said it might take legislation. The feds give states the option of allowing women to stay home with their infants for the first 12 months, but Michigan doesn't permit this. Right now, women with infants can meet the work requirement if they attend high school or training programs, or if they are disabled. Mary asked if we would recommend that MIHP be a way to meet the work requirement for all MIHP participants, or only those at high risk. The Steering Committee has discussed the DHS work requirement and Doug Paterson is aware of the issue. Brenda and Ingrid will follow up on this with renewed vigor, based on this discussion.

Pat said that we need to get everyone on WIC as soon as possible, and that WIC participation should also count toward the work requirement – we'd have healthier babies and save a great deal of money. She showed a bar graph that she just got at the WIC conference, which documents that participation in WIC is associated with lower African American infant mortality rates.

Pat said that the way they do WIC and MSS in northwest Michigan is different from how they do it in other parts of the state. WIC can choose how to dispense coupons: 1) either every 3 months or once per month, and 2) the woman can come to the WIC office to pick them up, or you can take them out to her house. MSS/ISS can take advantage of these options to create a system that works, as they have in northwest Michigan. She encouraged the DWG to look at what works and not to reinvent the wheel.

Some concern was expressed that women might skip WIC if they had to go through an extended visit to get an additional service they aren't interested in – we don't want to erode the positive, friendly relationship that WIC has with women. How do we ensure that women don't skip WIC because they don't want to spend the extra time?

WIC engages 80% of its target population. The 20% who are not engaged are the women at highest risk for the poorest outcomes (our priority sub-population). We need to know more about the 20% (are they chronically mentally ill, involved with CPS, etc.) to be able to do effective outreach. Do we have any data on where they are? Maybe we can reach that 20% through the social contract strategy. Once the entire target population is identified in the database, we'll know who they are. Tom said that one of the four activities the IHCS is proposing for their next contract year is to identify other access points at which to engage women.

Peggy asked if data is available on infant mortality among non-WIC participants. There should be – IHCS could pull it out of the data warehouse.

Sandy said that her experience working as a provider in a high-risk clinic and in a health plan is that WIC women are motivated. They know how to work the system to their benefit. The other 20% are not motivated and don't want to be found. They know they can get health care, but Sandy can't find them through the health plan. When Sandy gets

contact info on a new health plan member, she sends her a packet of info, but doesn't hear back from the woman. Sandy waits a month and then looks at claims data and finds that the woman has been to the ER. This is where the 20% is getting their health care - in the ER. We can enroll these women in Medicaid, but they'll still go to the ER. Maybe we should just put an MIHP worker in the ER.

Sue G. said that her program works with 2 health plans. They combine their prenatal, nutrition, transportation databases and download the lists to for Sue. Then Sue's staff tries to contact the women by phone, letter, etc. More and more contact is occurring – they're finding that the one-on-one works.

We need to get to the women who go to ER with stomach pain and find out they're pregnant. Some women don't want to join health plans – they want straight Medicaid so they can have their choice of providers.

Health care providers are denying services because woman can't prove they're on Medicaid – some say it takes them 2-3 months to get on. Some DHS offices aren't following the policy of issuing guarantee of payment letters (although last year 30,000 letters were issued).

We need to put posters and fliers in teen shelters, clinics, ERs, WIC offices, etc. on Medicaid and the MIHP. WIC has 1 800 number that patches the caller in to her local WIC clinic. We've never had resources for this type of thing, but maybe a PR campaign would help.

Do the WIC people think they can handle the additional responsibility of screening for MIHP? WIC staff are very involved with the MIHP redesign.

MIHP Data Reporting / Registry / Tracking Workgroup

Sheila Embry is the chairperson of the MIHP Data Reporting Workgroup. She explained that this internal group includes data analysts, programmers, program staff and consultants representing Medicaid, managed care, maternal-child health, DIT, and IHCS. The workgroup is responsible for developing the initial method that providers will use to report data to the state, and for the developing the comprehensive web-based data reporting system over the next three years. The involvement of the DIT people is critical in terms of developing the web-based system.

Over time, the workgroup will:

1. design the registry data reporting format
2. develop registry data transfer procedures – when, how, etc.
3. build the registry
4. develop reminder / recall procedures
5. develop protocols for all of these components.

Right now the workgroup is identifying the critical elements that providers will report on as of Oct. 1, 2005. Initially, we will be asking for basic information - demographics, some of the elements in the screen, identified risk factors, etc. We will provide you with a document for reporting that will be used to track and analyze outcomes. We will ask you to report on new clients only – not to go back and report on those who are already in the program.

Sheila noted that the workgroup surveyed MICR to get a sense of the pitfalls they experienced as they developed their registry, and MICR provided a useful scenario of how they got to their web-based system. We are looking at all the mechanisms we have in place for getting info and finding out if providers are using them. We're working with WIC – they're revising their data system now too, and they are at the table.

The outcomes we get out will only be as good as the data that providers report in. The workgroup understands that there will be a learning curve for everyone, and will provide the training and support that providers need to use the new system. Sheila will keep the DWG up to date on the workgroup's activities.

Ingrid recently surveyed providers to see where they're at in terms of data reporting. She reviewed a handout on the survey results titled, "MSS/ISS Fact Sheet". She got a good response rate (66%) in a short period of time. Results:

- 100% of the respondents have Internet access.
- 47% have both Access and Excel; 41% have Excel only; 2% have Access only.
- Different providers use different tracking systems – there isn't one that's used by a majority of the respondents.

Providers are tracking everything from basic demographics to a wide range of indicators reported on extensive spreadsheets. It seems promising that the majority of providers are already tracking many of the elements we are interested in. Ingrid will ask providers if they can share their data templates with us.

Maternal Screener

Tom Summerfelt presented for Lynette Biery, who was unable to attend today's meeting. He said IHCS is piloting the current version of the maternal screener in 3 communities. In District 10, MSS nurses are doing the screening; in Genesee, community health workers (CHWs) are doing the screening, and in Kent, MIHP screening is embedded in the WIC process. Overall, it is taking 20 minutes on average to complete a screen. This is probably an overestimate, because it takes time at front end to get consent to participate in the research project. Nurses and CHWs are having equal success at getting women to disclose.

Paul said that although you may save time when you don't have to get consent for the research project, experience indicates that time is needed at the front end to build trust, and that the sequencing of the questions is very important, with the more personal

questions coming later in the interview. Is this being tested at the pilot sites? Tom said IHCS is capturing this data, but hasn't analyzed it yet. Women are being asked how they felt about answering these questions. Since we're piggybacking on WIC, we may be benefiting from women's positive feelings toward WIC. The 20% of eligible women who don't participate in WIC may perceive these questions as more threatening.

Sue Gough said that her staff begin an interview by giving a description of the program and explaining where they got the woman's contact info, as women are very concerned about this. This puts them at ease. It really only takes about 5 minutes to establish trust.

Tom said that in response to feedback we received at the April MSS/ISS training sessions, IHCS would add nutrition questions to the screener. We've also gotten some feedback suggesting that we should do a more robust capture of mental health history. We've gotten lots of feedback through the MIHP web site.

Kent Co. is using an interpreter to pilot the screener with Spanish-speaking women. The bulk of the women served by MSS/ISS speak English, but some programs have 80-90% of women speaking Spanish, many of whom are at low literacy levels.

The MIHP/WIC screener integration conceptually seems great because there is much overlap between the MIHP and WIC tools. However, the overlap wasn't as great as we'd hoped. WIC used to take 15 minutes to complete their process – the combined tool takes 45 minutes. Some WIC questions are federally mandated so we can't change the wording even if they overlap with ours, although we may be able to adjust some of the MIHP questions. WIC had been sending the screener out ahead of time and just reviewing it with a woman when she came in. IHCS will collect info from providers and recipients on going through the 45-minute process. There are pros and cons on both sides (integrating and not integrating the tools). The length of the process has implications for the case rate.

Pat asked Tom what difference he feels there is between sending the screener in advance and reviewing it with the woman when she comes in, vs. asking her to respond to each question on the spot. Pat believes that sending it in advance gives the woman more time to respond thoughtfully. Tom said that from a research perspective, it would only matter if we got different answers (e.g., because the woman's mother fills it out for her at home). Pat said that when you review the completed form, you discuss any apparent discrepancies.

Sue G. said that when her program sends the screener out, they get less data than they do when they make phone calls, as interviewers are trained to ask follow-up questions. Tom said the major concern would be women wondering who is going to see this form and asking themselves how honest they should be about smoking, drugs, drinking, etc. Pat said that we tell women they don't have to answer any questions that they don't want to answer. Literacy is an issue, but even if only 50% of women show up with their forms

completed, it speeds things up considerably. Peggy said that MOMS found that self-administration resulted in better disclosure.

We have talked about doing multiple screens over time, but the follow-up screens would be shorter. One of the best practice articles on the MIHP web site said that depression often shows up at end of 2nd trimester. Tom said that DCH and WIC would need to figure out how frequently they want to do follow-up screens, as this issue transcends the data research arm of project. Another issue that needs to be looked at is the WIC no show rate, which is about 30%, depending on the clinic.

The pilots are still in process, having been slightly delayed due to tech glitches. Now all 3 sites are piloting the paper version. One site has screened nearly 100 women and the others are closely approaching that number. With the electronic formats, we can program in an algorithm so at end of the screening, you'll get a report on risk codes and a summary of MIHP risk stratification.

As the pilots wrap up and IHCS looks at the input from all of the stakeholders, they will revise the screener, adding some questions and perhaps dropping some that didn't work. Their goal is to add no more than 4-5 minutes in the time it takes to administer it. The DWG will get the revised draft sometime this summer. Brenda noted that we'll be reasonably comfortable with the tool when we implement it, but that we can revise questions over time to improve it.

Infant Screener

IHCS has been consulting with researchers and practitioners on the development of the infant screener. The screener will incorporate the Ages & Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire – Social Emotional (ASQ: S/E), as well as some additional wraparound questions to make it fit our purposes (e.g., birth history, environmental issues, breastfeeding, etc.) We will not drop any of the questions on the ASQ or the ASQ: SE. The ASQ was originally designed for use in pediatrician's offices, is valid and reliable, and already is being used by many early childhood providers in Michigan. If a woman scores high-risk on the maternal screener, does her infant automatically become high-risk as well? Good question – we are working with them as a pair, as the MSS/ISS program split hasn't promoted continuity of care. However, we still would screen both the mom and the infant because the screeners provide necessary information for development of the care plan.

Sr. Barbara asked what we will do for follow-up based on ASQ scores if an infant falls within the range of concern. It would depend on the issue of concern, but we haven't developed the clinical pathway / protocol for this yet. Sister said that the ASQ doesn't work for premature babies – it doesn't go down low enough – these babies may go home from the hospital before their "birth date". From 6 weeks to 3 months, we're primarily dealing with regulatory issues, but we can't wait for 5 months to look at the baby's development. Sr. Barbara is working with Mary DeWeiss in Grand Rapids to develop a

tool for preemies. Premature babies are usually on the Early On path. IHCS will have draft of infant screener to us soon.

What's Possible by Oct. 1, 2005?

Brenda reviewed the handout titled **MIHP Rollout for October 1, 2005 – Draft**, which covered 7 points. Most of the discussion centered on the first two points:

1. We originally said we'd have contracts as of Oct. 1 between DCH and providers, as the vehicle by which we would convey the new program requirements. However, this won't work because time is too short, so instead we will use the Medicaid policy process, combined with letters of instruction. This means we're not tied quite as literally to the Oct. 1 timeframe. Policy promulgation takes 30 days for public comment, 30 days for DCH to process the comments, and a 30-day wait period prior to implementation once the policy is published - a total of 90 days.
2. Begin use of the new screening/assessment tool. There will be a Part A and a Part B. Part A is the new maternal screening/assessment tool and Part B consists of whatever supplemental questions aren't being asked in the new tool, but which we think we need for now (during the transition period). Providers would bill for the screenings/assessments the same way that they currently bill for assessments. We want to get this in place for Oct. 1, but there are many nitty-gritty details to work out, as we need to write protocols and provide training on using the new tool prior to implementation. It was noted that with respect to the second bullet under number 2 on the handout – these are two different codes (home visit/assessment billing code), not one code.

Jackie and Alethia said that we need to know what's happening with the pilots before we can draft protocols and policies on this. How are the pilots using the new maternal screener to write care plans? How is the new process working?

Paul asked how much detail has to be included in the policy. Jackie, who is responsible for writing the policy, said that this is hard to answer - in general, the clearer, the better. She said her problem with writing the policy is how to clearly say all of this. Can we say we'll approve Parts A & B and that providers can choose what they need, so we don't have to nail down everything in print? Jackie said this could still be problematic. We can make changes later, but we have to say which tool we want them to use – we don't want providers using 5 different tools. Can we say if a woman scores low risk on Part A, don't use Part B? Ingrid said that if we want to standardize our program, providers have to use the same tool. We have to say which parts to use and which to drop. Jackie said that even then, she still has many problems to deal with to be able to write this policy – she just can't say “here's the tool – use it” – she has to give some level of detail.

Tom said that IHCS just provides the data, but would participate in a meeting to help facilitate the decision about the tools that will be implemented Oct. 1. Brenda said that

this is ok, so long as we know we need 90-100 days to get the policy through. She said that in the next few weeks, we'd land on what we want to do with this.

Pat said that since this tool drives the whole program, getting it out the door without understanding how the whole program works is shortsighted. She said there are so many unanswered questions that she doesn't know how Jackie could even begin to write the policy. We don't even know how a "contact" is defined on the matrix. As soon as we begin using the screener, it changes the population we're serving, but without knowing what we're supposed to be doing with them.

Sue M. said that the screener is the new assessment. As of Oct. 1, providers will collect the exact same information you collect now, only it will be in Part A or Part B. It's just that it will be reformatted—nothing will be left out between Parts A and B. All the risks that got women in before are still there. There will be no stratification as of Oct. 1. You will provide the same interventions you provide now—deliver services the same way, except in some cases, you could try some of the new interventions.

Sandy said she's been to almost all of these meetings and wonders if we're back-pedaling. At our first meeting, the slides showed we needed to reach the women at highest risk. But on the intervention matrix, if a woman is not willing to cut back on her smoking, she doesn't meet eligibility requirements to get in the program? Sandy asked why is Oct. 1 so important? Why can't we wait to get the tool we want that meets all of our needs? She said she felt the IHCS is rushing this.

Stacey explained that IHCS has been working on the MSS/ISS redesign since February or March 04. DCH asked them to come up with population management model with risk stratification, outcomes, evidence-based interventions, etc. for rollout on Oct. 1, 2005. IHCS came up with 3 different models: 1) carve-out model (DCH would hire a vendor, 2) fundamentally web-based model (3 years down the road), or 3) the middle-of-the-road model (staged implementation over 3 years using current providers). DCH chose the 3rd model and set the date for implementation, not IHCS.

Brenda reiterated that DCH is responsible for the MIHP and is setting the timeframes. Change is hard - no matter how we do it, some people will say we're moving too fast. But we have so many dollars going into this program without outcomes to show for it that we can't afford to wait. DCH is under intense pressure to show outcomes and Medicaid funding is at risk. If we're going to say MIHP is an important piece of Michigan's overall strategy to reduce infant mortality, we've got to demonstrate positive outcomes. We have to move as fast as we possibly can.

Betty said there has to be better outreach and targeted interventions. Brenda noted that we're using the evidence-based practices matrix, but we don't expect to have all of the interventions ready in all of the domains in one fell swoop.

Sue G. said it would be helpful to know how we will integrate the screener with the next step. How have the 3 pilots been starting care once the screening is done? They'll know

if we need Parts A & B. IHCS will meet with the pilots again on June 6 and can have this discussion with them.

Tom said he would encourage DCH, with the help of IHCS, to clarify what this scaffolding approach means for providers in each quarter of FY 06. Do they screen and deliver services the same as before? How do we define a contact/visit? What do providers need to be able to make the changes? A big problem is that the care plan doesn't match the assessment. Alethia said that providers are saying that whatever the policy is, they want to know what the changes are. Sue G. said it has to be clear from the beginning or it will be a mess at the local level.